City of Boston - Workers' Compensation Services
REPORT OF OCCUPATIONAL INJURY OR ACCIDENT

This form **MUST BE COMPLETED IN FULL** *and forwarded to Workers' Compensation Services, Boston City Hall, Room 613, Boston, MA 02201* **WITHIN 48 HOURS OF THE TIME OF INJURY OR ACCIDENT.** **PART I** (Sections A to G) *to be completed by the employee.* **PART II** (Sections H and I) *to be completed by the supervisor. If you have any questions about the completion of this report or workers' compensation matters, call 617-635-3193..* **PLEASE PRINT OR TYPE.**

PART I

SECTION A - EMPLOYEE INFORMATION

Last Name:	First Name:	Middle Initial(s):
Home Address: Street:	City:	State: Zip Code:
Home Telephone:	Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single	Social Security Number:
Date of Birth: (MM) (DD) (YY)	Date of Hire: (MM) (DD) (YY)	Hourly Wage: $
No. of Hours Worked Per Day: / No. of Days Worked Per Week/Shift:	Regular working days: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat	Average Annual (52 Week) Wage: $ ☐ Actual ☐ Estimated
Regular Occupation:	Occupation at time of accident:	Was employee performing regular occupation when accident occurred? ☐ YES ☐ NO
Union/Bargaining Unit: / No. of Dependents:	Has this employee ever claimed Workers' Compensation before? ☐ YES ☐ NO	If yes, Date Workers' Compensation last claimed: (MM) (DD) (YY)

SECTION B - DEPARTMENT INFORMATION

Department/School/Budget Program Name:		
Department Address: Street:	City:	State: Zip Code:
Telephone:	Fax:	

SECTION C - INJURY/ACCIDENT INFORMATION

Date of Injury/Illness/Accident: (MM) (DD) (YY)	Time of Injury/Illness/Accident: ☐ a.m. ☐ p.m.		Date Injury/Illness/Accident Reported: (MM) (DD) (YY)
Name of person that the injury was reported to?	Position:	Telephone No.	Was more than 4 hours of work lost on the date of injury? ☐ YES ☐ NO
Will time be lost beyond the date of injury? ☐ YES ☐ NO	If accident resulted in death, Date of Death: (MM) (DD) (YY)		First Lost Work Day: (MM) (DD) (YY)
Regular Start Time: ☐ a.m. ☐ p.m. / Regular End Time: ☐ a.m. ☐ p.m.	Did accident occur on the City premises? ☐ YES ☐ NO	If No, provide address:	
Name of witness:	Address:		Telephone No.:

SECTION D - TREATMENT, REHABILITATION & RETURN TO WORK INFORMATION

Was the injured worker transported for treatment? ☐ YES ☐ NO	If Yes, form of transportation: ☐ Ambulance ☐ Drove self ☐ Supervisor ☐ Other	Was any treatment given at the accident site? ☐ YES ☐ NO
Name of treating Physician:	Address of treating Physician:	Date of treatment: (MM) (DD) (YY)
Name of treating Hospital:	Address of treating Hospital:	Date of treatment: (MM) (DD) (YY)
Date of Return to Work (if applicable) (MM) (DD) (YY)	Did employee return to regular occupation? ☐ YES ☐ NO	If No, occupation that employee is performing:

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SECTION E - NATURE OF INJURY OR ILLNESS

Nature of injury or illness To Body Parts (Burn, Fracture, Cut, Arm, Leg, Back, right or left etc.)

Source of injury or illness (e.g. machine, etc.)

SECTION F - THE ACCIDENT

Describe the circumstances leading up to and including the accident:

What do you think was the source of this accident (e.g. faulty equipment etc.)

SECTION G - EMPLOYEE'S VERIFICATION OF REPORT AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby verify that all of the information contained in this report of occupational injury or accident is accurate to the best of my recollection of the circumstances leading up to and including the incident which caused the injury. I also acknowledge and provide my consent to the City of Boston, Workers' Compensation Services and/or their agent to obtain medical records and reports relating to this injury.

Employee's Name (PRINT):	Occupation:
Employee's Signature:	Date Report Completed: (MM) (DD) (YY)

PART II

SECTION H - CORRECTIVE ACTION

Has there been a follow-up investigation conducted into this report of accident? ☐ YES ☐ NO

If No, why not?

If Yes, what correction action has been taken to prevent a similar accident from happening? (e.g. equipment repaired etc.)

Do you have any additional recommendations for preventing injuries of this type?

SECTION I - SUPERVISOR'S VERIFICATION OF REPORT AND INVESTIGATION

Supervisor's Name (PRINT):	Title:
Supervisor's Signature:	Date Report Completed: (MM) (DD) (YY)

WORKERS' COMPENSATION OFFICE USE ONLY

Date Received in WC Office: (MM) (DD) (YY)	Case Manager:
File No.	Claim Status: